Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 6, 2022	2022_891649_0006	008886-20, 017615-20, 019149-20, 025932-20, 000579-21, 000663-21, 007652-21, 014247-21, 014564-21, 016319-21, 016706-21, 019159-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

Cummer Lodge
205 Cummer Avenue North York ON M2M 2E8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIEANN HING (649), STEPHANIE LUCIANI (707428), WING-YEE SUN (708239)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 2, 3, 4, 7, 8, 9, 10, and 11, 2022.

The following intakes were completed during this Critical Incident System (CIS) Inspection:
Logs #008886-20, CIS #M512-000012-20, #019149-20, CIS #M512-000017-20, #025932-20 CIS #M512-000022-20, #000579-21, CIS #M512-000002-21, #000663-21, CIS #M512-000003-21, #007652-21, CIS #M512-000013-21, #014247-21, CIS #M512-000023-21, #014564-21, CIS #M512-000026-21, #016706-21, CIS #M512-000031-21, #019159-21, CIS #M512-000036-21 related to falls prevention and management
Log #017615-20, CIS #M512-000016-20 related to a missing resident, and
Log #016319-21, CIS #M512-000029-21 related to resident to resident abuse.

PLEASE NOTE: A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c. 8, s .6. (7) identified in a concurrent inspection #2022_891649_0005 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Infection Prevention and Control (IPAC) Practitioner, Personal Support Workers (PSWs), cleaner, heavy duty cleaners and residents.

During the course of the inspection the inspectors observed staff to resident interactions, reviewed residents' clinical records, staffing schedules and observed IPAC practices.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan.

(i) A resident’s plan of care stated that their call bell was to be within reach as a falls prevention intervention.

The resident's call bell was observed hanging on the wall at the foot of the bed and not within the resident's reach.

Failure to ensure that a resident’s call bell was within reach may result in an increase in the risk of falls and injury and a delay in staff responding to care needs.

Sources: Critical Incident System (CIS) report, resident’s plan of care, observation of the resident, and staff interviews with a PSW and DON.[707428]

(ii) A complaint was reported to the Ministry of Long-Term Care (MLTC) alleging that a resident was not provided with feeding assistance.

A PSW assisted a resident with beverages, soup and dessert but after the resident refused their soup, they were not offered the entrée portion of their meal. The resident’s plan of care indicated they required assistance with eating and that staff should serve all

meal items together. The PSW and DON stated that the resident should have been offered their entrée. The resident was identified at high nutritional risk.

Failure to ensure the resident was served their entire meal could have limited their oral intake and compromised their nutritional status.

Sources: Observation of lunch meal on March 7, 2022, the resident’s care plan, and interviews with the PSW and other staff. [708239] [s. 6. (7)]

2. The licensee has failed to ensure that two residents were reassessed and the plan of care was reviewed and revised when care set out in the plan was no longer necessary.

(i) A resident's plan of care stated that a specific device should be applied as a falls prevention intervention.

The specific device was not utilized by the resident.

The PSW said that the resident no longer required the device. The Registered Practical Nurse (RPN) stated that the resident’s plan of care was not updated to reflect a change in care, and that registered staff were responsible for this update.

(ii) A resident’s plan of care stated that they required a specific device to be utilized at all times to prevent an injury from falls.

The resident was not utilizing the device while in bed. The next day, the resident was sitting in a chair, and the specific device was not utilized.

The Registered Nurse (RN) stated that the resident’s plan of care should have been updated since they no longer required the specific device.

Failure to update two residents' plans of care when the residents care needs changed increased their risk of receiving improper care.

Sources: (i) Sources: CIS report, the resident’s plan of care, observation of the resident, and staff interviews with the PSWs, RPN, and DON.

Sources (ii) CIS report, the resident's plan of care, observation of the resident, and staff interviews with the PSW, RN, and DON. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that pain medication was administered to a resident in accordance with the directions by the prescriber.

A resident was assessed as having pain. Pain assessments were completed for the resident on two consecutive days. The resident had orders for scheduled pain medication three times a day. The resident's medication audit report indicated that scheduled pain medication was not administered to the resident as prescribed twice during a two day period.

The RPN, RN, and DON confirmed that pain medication was not administered to the resident as prescribed.

Failure of staff to administer scheduled pain medication to the resident as prescribed put them at risk of not having their pain adequately controlled.

Sources: The resident's electronic-medication administration record (e-MAR), Medication Audit Report, pain assessments, CIS report, interviews with the RPN, RN, DON, and other staff. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. 1.The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal and snack service.
Observations of the home’s hand hygiene practices were as follows:

(i) During a lunch observation on two home areas residents were brought into the dining room by staff, and were not provided assistance with hand hygiene prior to the meal service. These residents were observed eating and drinking independently.

(ii) During a snack observation on a home area residents were seated in lounge area prior to afternoon snack service. The PSW did not assist residents with hand hygiene, and residents were eating and drinking independently.

The home’s policy titled “Dining Room Service” directed staff to ensure hand hygiene was completed for residents prior to meal service.

The Infection Prevention and Control (IPAC) Practitioner and DON both stated that the staff should have cleaned the residents’ hands prior to serving any food.

Failing to assist residents with hand hygiene increase the risk of transmission of infectious disease.

Sources: Observations of meal service on March 2 and 3, 2022, observation of snack service on March 3, 2022, Guidelines for “Dining Room Service” Policy #RC-0523-02 - published on January 1, 2019, interviews with PSWs and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 8th day of April, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.